ALLIED PILOTS ASSOCIATION
VOLUNTARY SUPPLEMENTAL MEDICAL AND CUSTODIAL CARE BENEFIT PLAN CLAIM FORM

Return completed form to:
Luminare Health
P.O. Box 4187
Clinton, IA 52733-4187
1-877-498-8937

ALL CLAIMS MUST BE FILED WITHIN 1 YEAR OF DATE OF SERVICE,
NOTE: SUBMIT AN ITEMIZED STATEMENT OF EXPENSES THAT INCLUDES, NAME OF PATIENT, DATE OF SERVICE, AMOUNT OF CHARGES, ADDRESS WHERE SERVICE WAS RECEIVED AND PROVIDERS NAME, ADDRESS, PHONE NUMBER AND TAX IDENTIFICATION NUMBER.

SECTION A
Complete this section for all claims.

Name *(Last, First, Middle Initial)* | Employee Number | Social Security Number | Gender ☐ Male ☐ Female

Mailing Address (☐ *Check if new address)* | City | State | Zip Code | ☐ Married ☐ Single

Date of Birth *(Month/Day/Year)* | Spouse's Date of Birth *(Month/Day/Year)* | Date of Hire *(Month/Day/Year)* | ☐ American Airlines ☐ APA Staff

Day Telephone Number | Second Telephone Number | Status *(Check one)* ☐ Active ☐ Retired ☐ Medical Disability ☐ Surviving Spouse ☐ TAG ☐ Furloughed

Have you reached your lifetime maximum benefit under AMR health coverage? ☐ Yes ☐ No If Yes, has documentation been submitted? ☐ Yes ☐ No

SECTION B
Complete this section for Dependent claims only,

Patient Name *(Last, First, Middle Initial)* | Patient Social Security Number

Patient Gender ☐ Male ☐ Female | Patient Date of Birth *(Month/Day/Year)* | Relationship to Employee ☐ Spouse ☐ Child/Dependent | Patient Marital Status ☐ Married ☐ Single

SECTION C
Complete this section for all claims.

Are you or your dependent covered or eligible for coverage under any other group health coverage, including any other group health coverage through an employer or spouse's employer? ☐ Yes ☐ No

If yes, complete the following:
Eligible for the following plan: Plan Name _____ Effective Date _____
Enrolled in the following plan: Plan Name _____ Effective Date _____

PLEASE ATTACH A COPY OF THE EXPLANATION OF BENEFITS FOR THESE SERVICES.

SECTION D
Complete this section for all claims.

Is this patient **eligible** for Medicare? ☐ Yes ☐ No ***If Yes, complete the following:***

Medicare Part A (Hospital Insurance Benefits) Effective Date _____
Medicare Part B (Medical Insurance Benefits) Effective Date _____
Medicare Part D (Prescription Drug Coverage) Effective Date: _____

PLEASE ATTACH A COPY OF THE STATEMENT OF MEDICARE CLAIM PAYMENT.

SECTION E
Complete this section for all accidents or occupational illness/injury.

Date of Accident *(Month/Day/Year)* | Time of Accident ☐ AM ☐ PM | Where did the accident occur? *(City/State)* | Work Related? ☐ Yes ☐ No

Briefly describe the accident or occupational illness.

SECTION F
Complete this section for all claims.

ASSIGNMENT OF BENEFITS

Do you want us to pay the provider? (Doctor. Hospital, etc.) ☐ Yes ☐ No ***If Yes, please sign below.***

I hereby authorize payment of benefits otherwise payable to me up to the stated charges to the provider(s) of services for all bills included with this statement. I understand I am financially responsible for any amounts not payable or not covered by the plan.

Member Signature *(DO NOT sign here if you want the payment sent to YOU.)*

SECTION G
Complete this section if furloughed, TAG, a surviving spouse or a dependent child

CERTIFICATION THAT NO OTHER GROUP HEALTH COVERAGE IS AVAILABLE

I hereby certify that I have no Other Group Health Coverage ("OGHC'1, nor am I eligible for any OGHC, either through my employment or through my spouse's employment. Please note, Furloughed, TAG and Surviving spouse participants are not required to take the Company COBRA coverage. If you are eligible, or become eligible, for OGHC, you must take the other coverage.

_____
Signature of Furloughee, TAG, Surviving Spouse or Dependent Child age 19-26

SECTION H
Complete this section for all claims,

CERTIFICATION AND AUTHORIZATION

I certify that all the above statements are correct and complete and that the attached bill(s) represent actual services, dates and fees charged to me or my Eligible Dependents. I authorize the Plan and Its agents to take any appropriate action to receive expenses paid as the result of the acts or omissions of another person. To all Physicians, Hospitals, medical service providers, pharmacists, employers and other agencies or organizations: I agree that Luminare Health and their authorized representatives may see or obtain a copy of all medical, mental and dental care, drug or alcohol treatment prescribed drug, employment and insurance coverage records necessary for the proper administration of the Plan which pertains to patient. Such Information may be used to the extent deemed necessary by Luminare Health to determine the value or amount payable on account of this claim.

Member Signature | Date | Patient Signature *(if different)* | Date

NOTE: A photocopy of the above authorization is as valid as the original.